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A Study of Differences in Mental Health Status Among Rural and Urban Pregnant Women of Bihar

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ABSTRACT

This study is conducted to investigate the difference in mental health status among rural and urban pregnant women of Bihar. For this purpose 160 women age ranging from 25-40 years from different government and private hospitals of Jamui district. All the samples were collected through incidental cum purposive sampling technique. Correctional research design was used to analyze the data. All the data were analyzed on SPSS software. In this study it was found that mental health status and quality of life of rural pregnant women is better than the urban pregnant women; which will be better for their new born child. Having rich in fresh air, water and pollution free environment rural areas are better to live especially in the case of pregnant women. So it is suggested that women should settle in rural side areas during pregnancy time to give birth a heal their child. Decision of delivery in urban will be better decision at that time.

Keywords : Women, Hospitals, Mental Health, Quality of Life, Fresh, Pollution, Environment

Introduction

It is a well known fact the antenatal period is a very crucial time for women, since they face several physical, biological and psychological challenges. These physiological, psychological and social transformations are also described as crises (Hollway, 2010; Raphael-Leff, 2011)[1]. The psychological state of mother can affect the child in her womb and hence mental health problems of the mother can lead to various complications during child birth and child's health. Prenatal depression and anxiety in this period is one of the major risk factors for postpartum depression (Norhayati et al., 2015)[2]. Depression and anxiety are very common during pregnancy and after childbirth. One in three to one in five women in developing countries, and about one in ten developed countries, have significant mental health problem during pregnancy and after childbirth (WHO, 2008)[3]. According to Lee et al. (2007); Leigh & Milgrom (2008)[4], there are 13% of women experience depression depression and 54% experiencing anxiety during pregnancy. Most importantly these statistics are considered to be underrated as there are many cases of perinatal distress which remain diagnosed due to the stigma attached to the expression of mental health problems (Gavin et al., 2005; Leung & Kaplan, 2009)[5]. Prevalence of mental health distress has been found to be high both during antenatal and postnatal periods especially in the developing counties (Satyanarayana et al., 2011)[6]. If the ability of women to take care of their baby is compromise, the survival and development of the infant is at risk. Extensive researches are available on maternal mental health because of its significance on the well being of the fetus. Researchers have indicated an association between mental health problem during pregnancy and impaired attachment with neonate (Martins & Gaffan, 2000; McFarland et al., 2011)[7]. Maternal depression is directly linked to lower infant birth weight, higher rates of malnutrition, higher rates of diarrhoea disease, infections illness, hospital admission and reduced completion of recommended schedules of immunization in children. It also adversely affects the

physical, cognitive, social, behaviour and emotional development of children (WHO, 2008).

Mental health problems during pregnancy

1. Depression

Pregnancy is a time that burdens women both mentally and physically. The world Health Organisation (WHO) defines depression as "a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guild or low self-worth, disturbed sleep or appetite, feelings of tiredness and poor concentration (WHO 2016)[8]." Women from lower economic background, having one or more children can develop negative viewpoint towards pregnancy. Depression which exhibit during pregnancy is called antenatal depression. Its prevalence is estimate to 19-25% in low income nation and 10-15% in developed nations. Among them approximately 54% also suffer from post-partum depression (Kamali, 2018)[9]. It is predicted that the depression is rising by 22.5% contribution to both disability and mortality (Martin et al., 2007)[10]. One in eight women has the lifetime risk of depression which is more prevalent during pregnancy (Correa-de- Araujo & Yoon, 2021)[11].

2. Anxiety

According to Glover et al (2018)[12] anxiety symptoms are universal among pregnant women which also continue in the post natal period. Prenatal anxiety had direct consequences on fetus development (Behere et al., 2017)[13]. Experience of anxiety is found to be more during antenatal period than post natal period which is generally monitored (Kamali, 2018)[14]. Pregnant mothers suffer from pre eclampsia, nausea, vomiting, preterm labour and delivery, low birth weight of the baby, difficulties in breastfeeding, PTSD symptoms and elective c-section deliveries (Brockington, 1996; Martini et al., 2010)[15].

3. Stress

Stress during pregnancy is defined as "the imbalance that a pregnant woman feels when she cannot cope with the demands which is expressed both behaviourally and physiologically." (Ruiz & Fullerton, 1999)[16]. Studies have reported associations between psycho-social stress during pregnancy and domestic violence (Bullock et al., 2006; Curry, 1998)[17], depressive symptoms (Jesse et al., 2004)[18], psychiatric diagnoses (Spitzer et al., 2000)19, poor weigh gain and chronic medical disorder (Orr et al., 1996)[20]. Some of these factors identified as having association with poor birth outcomes are preterm delivery (Rodrigueset et al., 2008)[21] and low birth weight (Kelly et al., 2002)[22].

4. Somatic symptoms

Physical health is the primary focus during pregnancy and somatic complains are common to all pregnant women. Physical and hormonal changes during pregnancy demand for more care and attention (Webb et al., 2008; Brown & Lumley, 2000)[23]. Though somatic complains are manifestations of psychological distress its identification as expressions of mental health problem is difficult in lower income countries and middle income countries because of existing cases of malnutrition, undiagnosed diseases and limited availability of health services (Escobar & Gureje, 2007)[24].

Psychosocial factors affecting mental health during pregnancy

Social factors such substance abuse, impaired relationships and domestic violence are linked to the development of psychological distress among women. In India intimate partner violence and alcohol abuse by partner are widely associated with depression. Losses of social support lead to isolation as a consequent globalization, urbanization, modernization and migration. It amplifies the number of individuals experiencing depression, anxiety, stress and others mental health problems. Significant contributions of additional factors are also accountable for poor manifestation of mental health. Some of the include belief system, religion, ethnicity, caste, attitudes and poverty (Keynejad et al., 2020)[25]. As a result, development of a holistic perspective is essential to deliver care to the pregnant mothers in an integrated setting.

Similarly, marital status was found associated with anxiety and depression among pregnant mothers. Studies have identified that depression during antenatal period is higher amongst single mothers or those who are engaged in single parenting than married pregnant women and those living in a romantic relationship (Raisanen et al., 2014; Jeong et al., 2013)[26]. However, single mothers reported frequent depression as compared to the women having supportive

husbands, but less frequent depression was found as compared to those who had unsupportive husbands. On the contrary no association was found between marital status and antenatal depression in various studies (Agostini et al., 2015; Pereira et al., 2009)[27].

Objectives

1. To examine the difference between pregnant women of rural and urban areas on the measures of mental health.

Methodology

Sample

A sample of 160 women age ranging from 25-40 years; from different government and private hospitals of Jamui district were selected to complete this study. All the samples were collected through incidental cum purposive sampling technique. Correctional research design was used to analyze the data.

Tests and Tools

1. Mental Health Inventory developed by Jagdish and A.K. Srivastava.
2. Quality of life developed by S. Sharma and N. Narsenn

Analysis of Data

The collected data were analyzed through statistical software SPSS and other pusposeful statistical tools as per requirement of the data.

Result and discussion

Table- 1:

Differencse in mental health status among rural and urban pregnant women

Area	Status	Number	Percent
Rural	Very Good	0	0.0
	Good	28	17.5
	Average	104	65
	Poor	20	12.5
	Very Poor	0	0.0
Urban	Very Good	8	5
	Good	0	0.0
	Average	20	12.5
	Poor	56	35
	Very Poor	84	52.5

Source: ***Estimated from field survey; where N= 160 (Multi Answer Question)***

From table 1 we can see that mental health status of maximum rural pregnent women is average (65%) while urban pregnent women is very poor (52.5). Very good condition of mental health was found in only urban women with 5% only while in rural areas women ware found in good condition of mental health with 17.5%. Women in poor health condition was found in rural areas with 12.5% while in urban areas with 35%. Some 52.5% pregnent women was also found in very poor mental health condition in urban areas while no cases of very poor mental health conditin of women was found in rural areas. Thus it can be said that pregnent women in rural areas are in better mental health condition in compare to urban pregnent women.

Table- 2:

Differencse in quality of life among rural and urban pregnant women

Area	Quality	Number	Percent
Rural	Extremely High	0	0.0
	High	28	17.5
	Above Average	0	0.0
	Average	32	20
	Below Average	40	25
	Low	40	25
	Extremely Low	12	7.5
Urban	Extremely High	8	5
	High	0	0.0
	Above Average	0	0.0
	Average	0	0.0
	Below Average	0	0.0
	Low	48	30
	Extremely Low	112	70

Source: Estimated from field survey; where N= 160

From table 2 we see that quality of life of rural women is high (17.5%) while quality of life of urban pregnant women is extremely high but only with 5%.

Maximum urban pregnant women also accepted extremely low quality of life (70%) while in rural areas only 7.5% women accepted that they their quality of life is extremely low. Low in quality in quality of was accepted approx. same percentage of pregnant women of rural as well urban both with 25% and 30% respectively. Twenty percent (20%) rural pregnant women accepted that their quality of life is average while 25% accepted below average. No cases of above average, average or below average was found in urban pregnant women. Thus is throws that quality of life of rural pregnant women is also better than urban pregnant women. It also also indicates that rural life is healthier for new born child in compare to urban life.

Conclusion:

On the basis of the study it can be concluded that mental health status and quality of life of rural pregnant women is better than the urban pregnant women; which will be better for their new born child. Having rich in fresh air, water and pollution free environment rural areas are better to live especially in the case of pregnant women. So it is suggested that women should settle in rural side areas during pregnancy time to give birth a healthier child. Decision of delivery in urban will be better decision at that time.

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